The Influence of Caregiver and Cultural Factors on Child Inclination toward Disclosure

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ABSTRACT

Although a considerable body of research has looked at factors underlying mental health help-seeking behaviors, many facets of this pathway have received only marginal attention, particularly for internalizing concerns in children (Del Mauro & Williams, 2013). Moreover, caregivers and culture can exert a pronounced influence on family dynamics, conferring values and beliefs that can facilitate or inhibit help-seeking (Cauce et al., 2002). In a two-group study of international ($n = 20$) and domestic ($n = 20$) families, we sought to determine whether parental and cultural factors could differentially predict children's tendency to disclose, withhold, or mask internalizing (i.e., anxiety and depression) symptoms. Caregivers completed a battery of measures while children completed self-report questionnaires and an interactive activity to assess disclosure propensity. Results indicate that parenting and attitudinal factors are not necessarily implicated in predicting children's decisions for both anxiety and depression, and irrespective of cultural background. However, among international families, children's inclination toward disclosure of anxiety-related concerns reflected significant cultural influences (Wilks' $\lambda = .386$, Chi-square $= 15.230$, $df = 6$, Canonical correlation $= .729$, $p = .019$). Caregiver acculturation in particular was found to account for 84.2% of the variance, with children of less acculturated parents being more likely to mask as opposed to disclose or withhold.

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GENERAL AUDIENCE ABSTRACT

Although a considerable body of research has looked at factors underlying mental health help-seeking behaviors, many facets of this pathway have received only marginal attention, particularly for internalizing (i.e., anxiety and depression) concerns in children. Moreover, caregivers and culture can exert a pronounced influence on family dynamics, conferring values and beliefs that can facilitate or inhibit help-seeking (Cauce et al., 2002). In a two-group study of international ($n = 20$) and domestic ($n = 20$) families, we sought to determine whether parental and cultural factors could differentially predict children's tendency to disclose, withhold, or mask internalizing symptoms. Caregivers and children completed self-report questionnaires while children also went through an interactive story-based activity to assess disclosure propensity. Results indicate that parental styles and caregiver attitudes are not necessarily implicated in predicting children's decisions for both anxiety and depression, and irrespective of cultural background. However, among international families, children's inclination toward disclosure of anxiety-related concerns reflected significant cultural influences (Wilks' $\lambda = .386$, Chi-square = 15.230, $df = 6$, Canonical correlation = .729, $p = .019$). Caregiver acculturation in particular was found to account for 84.2% of the variance, with children of less acculturated (i.e., those families lacking social ties to the dominant cultural norms following immigration) parents being more likely to mask as opposed to disclose or withhold. Implications for guiding outreach to culturally diverse children and their families are discussed.

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Introduction

An extensive body of work has explored underlying cultural or interpersonal facilitators and barriers to psychological help-seeking for children struggling with internalizing symptoms. Lifetime prevalence of internalizing disorders—though difficult to accurately estimate due to differences across diagnoses, samples, methodology, and geography—among kids ages 13 to 17 can be as high as 14.4% for mood disorders and up to 32.4% for anxiety disorders (Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012). Although these psychiatric concerns have received substantial attention among older populations, they represent a particularly challenging area with children due to low insight and mental health literacy (Del Mauro & Williams, 2013).

The typical age of onset for most of these conditions occurs sometime in childhood and adolescence. In many cases, children and parents alike ascribe to the misconception that these symptoms will dissipate on their own, or that they do not constitute serious mental illness warranting intervention (Hinshaw, 2005). Although externalizing and disruptive disorders are also common, these are more readily noticed and addressed in children because of the distress they inflict upon caregivers and school personnel, with functional impairment being apparent in the home and school settings even from an early age. On the other hand, problems like anxiety and depression can go unnoticed because the consequences for children are not particularly overt. In some cases, the behavioral patterns that arise as a result of these debilitating conditions can appear adaptive. For example, Stöber and Joormann (2001) found that children with generalized anxiety disorder tend to do well in school because of the inordinate amount of time they devote toward reaching a perfectionist standard.

Studies suggest that there are distinctions in the type of thinking that underlies help-seeking for internalizing versus externalizing problems. A recent study comparing help-seeking for Attention-Deficit/Hyperactivity Disorder (ADHD) and for Depression among youth found that those with an externalizing condition were more likely to talk to parents, doctors, and to seek information from books and the internet (Lee, Friesen, Walker, Colman, & Donlan, 2014). This is promising for increasing mental health literacy, which in turn is associated with a greater awareness of psychological disorders that facilitates help-seeking (Horwitz, Gary, Briggs-Gowan, & Carter, 2003; Lee et al., 2014; Rickwood, Deane, & Wilson, 2007). However, those kids suffering from depression more often opted to change their habits (e.g., sleeping, eating) or simply wait for the condition to subside on its own (Lee et al., 2014).

Non-disclosure of anxiety and depression by children is problematic given that early symptoms predict the development and worsening of psychopathology later in life (Last, Hansen, & Franco, 1997; Rao et al., 1995). A similar methodology to our own was employed by Pineda (2013) in a study looking at mental health literacy in Latina women regarding school-age children. Participants in this study were presented with vignettes detailing either healthy children with no clinical concerns or children going through a range of psychological difficulties. Several factors accounted for mothers' ability to recognize symptoms, and their own willingness to seek help for the child, such as history of interpersonal violence and acculturation (another important area for research into family help-seeking, detailed below).

The first stage on the pathway to securing professional psychological services for anyone struggling with mental health concerns is recognition of a problem (Cauce et al., 2002). In the case of adults, recognizing psychological distress can be enough to precipitate enrollment into treatment, or at least present the possibility, barring other barriers to care. For children and

adolescents, however, there is another—often difficult and complicated—step: disclosing these symptoms to primary caregivers or other advocates (e.g., teacher). The determining factors in how children speak up about internalizing disorders are myriad (Rickwood et al., 2007). They can be related to the type and severity of concerns (Del Mauro & Williams, 2013; Lee et al., 2014) or to other personal beliefs and characteristics ranging from self-efficacy to age and gender (Dindia & Allen, 1992; Gulliver, Griffiths, & Christensen, 2010; O'Connor, Martin, Weeks, & Ong, 2014). In addition, the combined influences of family supports or practices (Oh, Mathers, Hiscock, Wake, & Bayer, 2015) and cultural or societal considerations (Alegria, Atkins, Farmer, Slaton, & Stelk, 2010; Harrison, McKay, & Bannon Jr, 2004; Snowden & Yamada, 2005) play a role.

Once a child decides to disclose, they are posed with the challenge of identifying the person to whom they will turn. Multiple studies have looked at help-seeking in adolescents and young adults, but there is paucity in the research on this in children. For example, Del Mauro & Williams (2013) found that adolescents tend to turn to other networks for self-disclosure, including peers, teachers, counselors, and family. In contrast, due to limited independence, children rely almost exclusively on their primary caregiver to decide the appropriate course of action following disclosure of psychological concerns (Lee et al., 2014).

The bulk of the literature on help-seeking and childhood mental health suggests that a child's point person is most often the parent or primary caregiver (Frijns, Keijsers, Branje, & Meeus, 2010; Mayberry & Heflinger, 2013; Sayal, 2006). Not only do caregivers frequently act as the intermediary between a child and professional help, they also impact a child's disposition across all three of the aforementioned domains: parenting, attitudes, and culture. Through parenting, caregivers can shape a child's schemas and attitudes (Varela, Sanchez-Sosa, Biggs, &

Luis, 2009), and establish the rules and expectations in the home that will extend to other settings. Evidently, it is impossible to address childhood pathways into mental health services without considering the integral and often active role caregivers play from the onset of internalizing concerns in children to the eventual outcome, be it amelioration or aggravation (Rapee, 1997; Yap, Pilkington, Ryan, & Jorm, 2014).

Nevertheless, the nuanced effects parents have on children's attitudes or views toward mental illness are unclear. One study conducted by Chandra and Minkovitz (2006) looked at the impact of parental disapproval and perceived stigma on childhood help-seeking and found that these factors were relevant in explaining the relationship between gender differences and willingness to seek help among adolescents. To our knowledge, there are no published studies on convergence of attitudes toward mental illness between caregiver and child. However, research in fields such as politics and racial prejudice support the notion that parents transmit certain facets of their perspectives onto their children (Jennings, Stoker, & Bowers, 2009; Sinclair, Dunn, & Lowery, 2005). Two other studies suggest that the family's reaction to learning of a child's mental health problems is an important point children take into account when determining their course of action related to disclosure (Ballon, Kirst, & Smith, 2004; Cohen, Medlow, Kelk, & Hickie, 2009). However, these expectations are largely predicated on the overall style of interaction and upbringing experienced by children (Bögels & Brechman-Toussaint, 2006; McLeod, Weisz, & Wood, 2007; McLeod, Wood, & Weisz, 2007). Parents are also uniquely entwined with a child's cultural upbringing. They introduce traditions and belief systems that lay the groundwork for that child's cultural orientation (Spencer, 1983; Zayas & Solari, 1994).

In discussing familial interactions as they pertain to disclosing internal distress, one would be remiss to overlook the diverse cultural contexts in which parent-child dynamics develop and exert their influence. Research heterogeneous in its conceptualization of what exactly cultural background entails. Past studies have tapped into culture using a wide variety of indices, including such proxy characteristics as race and ethnicity, immigrant generational status, degrees of acculturation to the dominant culture (Pineda, 2013), enculturation, ethnic identity, and value-oriented scales (e.g., familism). With regard to racial differences, research suggests that ethnic minority youth are significantly less likely to talk to parents, doctors, or friends than are majority children (Lee et al., 2014; Lindsey, Roberts, & Campbell-Jones, 2013; McMiller & Weisz, 1996). Ethnic groups vary in the degree to which actual need maps onto service utilization. One study found that race can predict whether parents will consider seeking professional services whereas the child's age and gender influence whether the parent will move forward and talk to a professional (Horwitz et al., 2003).

Although numerous components contribute to the overarching concept of culture, it is impossible to tease apart these effects entirely, and unwise to lump them into one comprehensive measure that is intended to capture "culture" broadly. Another major hurdle faced by culturally-oriented research is socioeconomic status, as oftentimes cultural minorities tend to come from lower socioeconomic backgrounds (Fine, Schwebel, & James-Myers, 1987; Julian, McKenry, & McKelvey, 1994). From the many listed cultural components, the one which is perhaps most pertinent to an examination of caregivers and the contextual effects conferred unto youth would be the familial values (Arends-Tóth & Van de Vijver, 2009; Byrne & van de Vijver, 2014; Marín & Gamba, 2003). Specifically, the notion of *familism* spans several cultures and can largely differentiate between certain cultural subsets (Steidel & Contreras, 2003). Familism refers to

beliefs and attitudes regarding commitment to the family unit as paramount such that it supersedes consideration for individual needs. Another important component is acculturation (Marín & Gamba, 2003; Perez Rivera & Dunsmore, 2011; Zayas & Solari, 1994), which refers to an individual's acceptance of and identification with a new society's values, norms, and customs (Yoon et al., 2013). Its counterpart, enculturation, has to do with the extent to which an individual continues to live by or adhere to the tenets of their native or ethnic group. The literature suggests that among ethnic and cultural minorities, a balance of acculturation and enculturation is associated with lessened stigma (Liao, Rounds, & Klein, 2005; Tata & Leong, 1994).

Research has shown that help-seeking represents an umbrella concept that encompasses multiple subcomponents such as disclosure and secrecy (Frijns et al., 2010). It is not sufficient to understand what leads children to seek help or not. Of arguably greater import is exploring the factors associated with specific help-seeking actions such as withholding or purposeful masking out of consideration for others. According to Frijns and colleagues (2010), secrecy differs from disclosure in that it involves a conscious and active effort to avoid discussion of a particular topic. The bulk of the extant literature on child help-seeking has been hampered by its reliance on self-report and focus groups (Rickwood, Deane, Wilson, & Ciarrochi, 2005), a notable limitation given the circular nature of relying on children to disclose their stance on disclosure. Even with the promise of anonymity, children's responses with respect to voicing psychological problems or attitudes toward help-seeking may reflect their notion of the "correct" approach (i.e., social desirability) as opposed to their actual mentality. Thus, the current study employed an interactive task to assess child attitudes toward help-seeking and disclosure in an innovative way that may complement or inform self-report findings. Additionally, through the use of multiple

informants and comparison groups based on cultural background (i.e., U.S.-born, "domestic" family dyads versus "international" families with origins abroad), the study addressed the influence of the various aforementioned factors (e.g., parenting, attitudes) within a contextual framework.

As a first step toward addressing the lapse in mental health care and the gap in the methodology of the current literature, the purpose of the present study was to advance a culturally sensitive understanding of the influence caregivers exert on children's willingness to speak up about emotional worries and concerns using an innovative approach. We sought to determine which caregiver factors play a role in predicting the disclosure-related decisions made by children from differing cultural groups (i.e., domestic-born vs. international).

The primary hypothesis was that children's disclosure-related decisions for anxiety and depression would depend on a linear combination of caregiver-reported care and overprotectiveness among domestic and international families. For the secondary hypothesis, we maintained that Children's disclosure-related decisions for anxiety and depression would depend on a linear combination of caregiver beliefs toward mental illness and attitudes toward help-seeking among domestic and international families. Finally, the third hypothesis stated that children's disclosure-related decisions for anxiety and depression would depend on a linear combination of caregiver acculturation, enculturation, and familism among international families.

Methods

Design

The power analysis for Discriminant Function Analysis (DFA) was conducted in the same manner as a multivariate analysis of variance (MANOVA) per guidelines set forth by

Cohen (1992). To detect a moderate effect size (*Cohens f^2* = 0.15) with a power of 0.80 and α = 0.05, the required sample sizes for each group was 20 (40 total families). Considerations for the targeted sample size included outreach for enough subjects within each group (particularly the subset of cultural minority subjects), and the availability of sufficient external funding for adequate participant compensation. DFA dictates that there should be at least 5 cases for each independent variable. Accordingly, each set of analyses was able to include up to 4 total predictors for each of the two samples, domestic families and international families. DFA tests were conducted separately for each of the two groups in order to more meaningfully understand which predictors would be most useful in discerning childhood help-seeking inclinations among the respective populations.

Participants

Participants included 40 child-caregiver pairs consisting of the primary female caregiver and a child (60% Male, 40% Female) between the ages of 9 and 12 (*M* = 10.40, *SD* = 1.11) recruited over the course of a year and a half in Southwest Virginia (*n* = 26) and South Florida (n = 14). Half of the families were considered US-born, hereafter referred to as "domestic" in that both members of the dyad were born in the United States. The other half of the families was classified such that the caregiver participant was originally born in another country; hereafter this group is referred to as "international." The rationale for targeting the indicated age range (9 to 12) was to address a gap in the literature related to the early establishment of help-seeking tendencies during a stage in life when caregivers exert considerable influence on their children.

We included any designated primary caregiver, as opposed to exclusively parents, out of consideration for the rising rates of non-parental guardian figures, especially among families from diverse ethnic and cultural backgrounds such as racial minorities and recent immigrants

(Gibson, 2002). Furthermore, in view of the literature citing pronounced differences between male and female caregivers (i.e., mothers versus fathers), the present study only included the primary female caregiver (e.g., mother, grandmother, aunt). Although this sacrificed ecological validity to some degree, it was the most feasible and logistically sound approach. In order to ensure gender matching for caregiver and child, including paternal figures would have required additional blocking. This methodology is consistent with the vast majority of research on caregiver and cultural influences on mental health service use or attitudes toward mental illness, which has been done with women and mothers (Alvidrez, 1999; Hudson & Rapee, 2001; Pineda, 2013). In our sample, 32 (80%) children came in with their biological mother, 5 (12.5%) were brought in by their grandmother, and 3 (7.5%) participated with their step-mother. Additional sample demographic characteristics are presented in Table 1.

We also collected information about the national origins and immigration backgrounds of the children and their parents and grandparents per the participating caregivers' reports. All 20 (100%) children from domestic families were born in the U.S. Of them, 15 (75%) had fathers also native to the U.S. while the other 5 (25%) fathers in the sample immigrated to the U.S. With respect to maternal grandparents in the domestic sample, 18 (90%) grandmothers and 19 (95%) grandfathers were native to the U.S., with the remaining sample having been born abroad before immigrating to the U.S. As for the paternal grandparents of the domestic families, 14 (70%) grandmothers and 14 (70%) grandfathers were born in the U.S., 4 (20%) grandmothers and 4 (20%) grandfathers were born in another country and immigrated, and 2 (10%) did not indicate.

With respect to our international sample, 9 (45%) of the children from the international sample were themselves born abroad and immigrated alongside their caregiver; the other 11 (55%) were born in the U.S. after their caregiver(s) immigrated. In the international sample, 4

(20%) fathers were born in the U.S., 9 (45%) were born abroad and immigrated to the U.S., 5 (25%) were born abroad and still reside outside the U.S., and 2 (10%) were unidentified. For international families, 10 (50%) maternal grandmothers were born abroad and immigrated to the U.S., 8 (40%) were board abroad and still reside in another country, and 2 (10%) did not report. As for maternal grandfathers of children in the international sample, 6 (30%) were born abroad and immigrated, 12 (60%) were born in outside the U.S. and reside there, and 2 (10%) did not indicate.

Measures

The Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Farina, 1995) is a 29-question self-report measure assessing an individual's perspectives on openness to receiving counseling and or psychological services. Respondents rate each item on a 4-point Likert scale from 0 (*disagreement*) to 3 (*agreement*). A total of 18 items on the ATSPPHS are reverse-coded prior to scoring. Higher scores on the ATSPPHS indicate more favorable views toward seeking outside professional psychological help. The caregivers were administered this measure in order to determine their own views on seeking help. In the present samples, we found an overall Cronbach's alpha of 0.895 for the domestic group and 0.921 for the international group.

The Attitudinal Familism Scale (AFS; Steidel & Contreras, 2003) is an 18-item measure developed to assess family-related cultural values such as familial support, familial interconnectedness, familial honor, and subjugation of self for family. Items are answered on a 10-point Likert scale ranging from 1 (*strongly disagree*) to 10 (*strongly agree*). High composite measure scores reflect a higher endorsement of "familism." The AFS has demonstrated high internal consistency for its overall scale score ($\alpha = 0.83$). For the current sample, we obtained an

internal consistency Cronbach's alpha of 0.882 for domestic families and 0.911 for international families.

The Beliefs toward Mental Illness Scale (BMI; Hirai & Clum, 2000) consists of 24 items used to measure 3 factors associated with mental illness attitudes including dangerousness, poor interpersonal and social skills, and incurability. Each item is rated on a 6-point Likert scale from 0 (*Completely disagree*) to 5 (*Completely agree*). No reverse coding is necessary for any of the items, and higher scores on the BMI reflect more negative beliefs and greater stigma toward mental illness. The psychometric validation analysis for the BMI suggests that it is a sound instrument with acceptable content, structural, and generalizable validity (Royal & Thompson, 2013). In our sample, we found n internal consistency values of 0.928 for the domestic group and 0.880 for the international group.

The Child Behavior Checklist (CBCL; Achenbach, 2009) is a parent-report measure developed for children ages 6 to 18 for assessing a child's competencies and problems. Like the ASR, this scale includes a few opening free-response questions related to general concerns and strengths. It also includes 112 items based on a 3-point Likert scale spanning 0 (*Not true*), 1 (*Somewhat or sometimes true*), and 2 (*Very true or often true*). Some items also prompt the respondent to provide more information. For the purposes of this study, this was used as an index of child psychopathology. The CBCL has demonstrated strong test-retest reliability for almost all measures ($r = 0.86$ to $r = 0.94$) and internal consistency coefficients ranging from moderate to very strong ($\alpha = 0.78$ to $\alpha = 0.97$).

We also included a Demographic Information Form. Caregivers were administered a series of questions pertaining to child's age and gender, as well as the caregiver's socioeconomic and marital status, relationship to the child, education, and treatment history. This form also

included a section on ethnic and cultural background, including caregiver ethnicity, child

ethnicity, and an overview of the child's family and generational background.

The Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979) consists of two

separate measures, one based on perceptions of the respondent's mother and another based on the

father. Each one is comprised of 25 items rated on a 4-point scale from 1 (*very unlike*) to 4 (*very*

like). Twelve of the items are reverse-coded prior to scoring. Research on the PBI suggests

acceptable to strong reliability and validity (Parker et al., 1979), as well as long-term stability

over a 20-year period (Wilhelm, Niven, Parker, & Hadzi-Pavlovic, 2005). In order to capture the

full spectrum of child-caregiver relationships, this measure was modified for the purposes of this

study and framed in reference to the child's accompanying primary caregiver. Further, since all

child subjects were younger than 16, the wording of the prompt was adjusted to reference the

child's overall views on the caregiver rather than experiences over the first 16 years of life. The

PBI has demonstrated good internal consistency and test-retest reliability, as well as satisfactory

construct and convergent validity independently of mood effect (Parker et al., 1979). Among

caregivers in the domestic group, the internal consistencies for the Care and Overprotectiveness

subscales were 0.806 and 0.507, respectively. For the international group, we obtained internal

consistency alpha values of 0.656 for Care and 0.784 for Overprotectiveness.

The Stephenson Multigroup Acculturation Scale (SMAS; Stephenson, 2000) is a 32-item

scale measuring the degree to which individuals with ties to other ethnic or cultural backgrounds

feel acculturated to their present sociocultural circumstances (e.g., American), and the degree to

which they remain enculturated with their group of origin. Questions are rated on a 4-point scale

spanning 1 (*false*), 2 (*partly false*), 3 (*partly true*) and 4 (*true*). This questionnaire will be

adapted to refer to another country of origin only if applicable. This is to ensure that those

participants who do not endorse strong ties to another culture have comparative data. According to Stephenson (2000), the SMAS demonstrated a coefficient alpha of 0.86 for the entire scale and alpha values of 0.97 and 0.90 for Dominant Society Immersion (DSI) and Ethnic Society Immersion (ESI), respectively. Item total correlations for DSI ranged from 0.51 to 0.87. For ESI, item total correlations ranged from 0.57 to 0.83. In our subsample of international families (n = 20), the DSI demonstrated an internal consistency of 0.91, and the ESI an alpha of 0.87. After conducting reliability analyses with respect to the domestic sample, we found internal consistencies of 0.44 for DSI and 0.92 for ESI. From the 15 items that factor into the ESI, 9 were found to have no variability (i.e., all respondents selected "4", resulting in a range of 0). Accordingly, the SMAS indices were not found to represent meaningful constructs for families without an identified country of origin different from the dominant country. Therefore, all subsequent statistical analyses of the SMAS were conducted solely with our international sample.

Finally, we administered a novel Disclosure Vignette Activity (DVA). In response to the notable lack of published or unpublished behavioral measures of disclosure, the present study developed a new task modeled after similar activities. The DVA involved a series of personalized vignettes that detailed the experiences of children with either anxiety or depression. In order to tap into the child's own attitudes, the child in the story was matched on age and gender. To offset the impact of including only female caregivers, the DVA was carried out by a researcher of the same gender as the child. Additionally, the caregiver's relationship to the child in the stories was matched with the participating caregiver in the dyad. At the end of each vignette, the child in the story had to make a decision regarding disclosure of mental health concerns (i.e., anxiety or depression). The participant was first asked for open-ended feedback

about the most likely decision the child would make. Afterward, the participant was provided four coded actions that the boy or girl in the story could take regarding disclosure. These options included Full Disclosure (F), Partial Disclosure (P), Withholding (W), and Masking (M). The child was asked to rank these four options in order from 1 (*most likely)* to 4 (*lease likely*), following the prompt, "Now, I want you to think about these four options and rank them in order of most likely to least likely on this chart." The present study used indirect prompts with the hope that children would respond in a manner consistent with their own intentions, without fear of stigma or judgment on themselves. After ranking the possible decisions, the child was given six additional cards with thoughts or reasons that may factor into each of the character's possible decisions. These supplementary rationale cards—intended for follow-up exploratory analyses— captured thought processes indicative of Acceptance (A), Burdensomeness (B), Hopelessness (H), Isolation (I), Lack of Insight (L), and Stigma (S). The subject was prompted to identify those thoughts which he or she felt reflected the logic behind each rank-ordered response. This task typically lasted approximately twenty minutes. Full Disclosure (F) and Partial Disclosure (P) were separated at the time of measurement to explore post-hoc what factors may account for greater insight or more detailed disclosure. However, for the initial analyses, we collapsed these two options to more clearly delineate the disclosure construct when running DFA.

Procedure

Several recruitment tactics were employed with the goal of reaching a diverse group of families. The sample was gathered from families residing in rural and urban areas of Virginia and Florida. Recruitment efforts included online and paper ads, email listings, outreach to church/youth groups (especially those with high minority group participation), and cultural fairs. All materials provided potential participants with a contact email address and phone number.

Interested caregivers were then contacted via phone to undergo the phone screen, go over any questions or comments, review the protocol, set a location, and schedule the appointment. All appointments took place in private office space settings convenient to the families, with the caregiver and child separating to complete their respective tasks.

At the start of each session, the lead researcher reviewed the consent document with the caregiver and the child together. Afterward, the child was brought into a separate exam room to meet with the gender-matched researcher who would go through the task with her or him. First, the researcher went through the assent form with the child. If both caregiver and child opted to participate, they were given $10.00 in cash as honoraria at that time. The caregiver was then individually administered the questionnaire battery (Demographic Information Form, PBI-P, ATSPPHS, BMI, AFS, SMAS, CBCL).

In the meantime, the child participated in the DVA. This task, detailed above, lasted approximately 15 to 20 minutes. Upon completion of the task, the child was offered water and a short break, after which the researcher reconvened with the child to administer, and assist as necessary with (i.e., reading the questionnaires and answering clarification questions), the self-report measures (PBI-C, YSR). The child and the caregiver were then brought back together for debriefing. At that time, the researcher(s) answered any questions and both participants were thanked for their time and cooperation. All data was entered SPSS, the same statistical program which was used to carry out all planned analyses.

Analytic Plan

First, the means and standard deviations were calculated for all predictors relevant to the central thesis questions, separated by cultural group. These included caregiver-reported parental care and overprotectiveness, attitudes toward help-seeking, beliefs about mental illness,

familism, and both acculturation indices. In addition, bivariate correlations among all of the aforementioned independent variables as well as possible control variables were carried out. A frequency table for the levels of the categorical dependent variable (disclosure choice selection) was also prepared. Preliminary analyses were then conducted in order to test the assumptions required to carry out discriminant function analyses (DFA). In order to ensure multivariate normality in the data, Box's test of equality of covariance matrices was used to detect any deviations.

Furthermore, these same descriptive and preliminary statistics were assessed to determine potential covariates and control variables, including income, child age and gender, and caregiver-report of the child's internalizing symptoms. If any of these were (1) not significantly correlated with another predictor and (2) significantly related to the dependent variable, they were to be included in the model. Finally, the validity checks on the DVA (e.g., name of the character, story's area of concern) were used to determine eligibility in the analyses. None of the children demonstrated flagged responses on the DVA validity checks.

DFA were used to conduct multivariate analysis of variance tests of the stated hypotheses. This statistical test is used to determine the relationship between a group of independent variables—in this case, parental factors—and the categorical dependent variable of child disclosure decisions (i.e., disclosure, withholding, or masking). Analyses were conducted separately for each of the two cultural groups, and for the two vignettes (anxiety and depression). Rather than combining both groups, we opted to conduct separate analyses in order to derive targeted conclusions about which factors predict disclosure decisions within a given context. While such an approach sacrifices the comparisons that can be drawn between groups, it provides more focused findings to inform intervention and outreach efforts for each respective

population or domain (e.g., which factors are specifically implicated in international children's decisions to disclose about anxiety).

If any control variables were identified for a given analysis, they were added first, followed by the set of independent predictors. First, a DFA was used to test the hypothesis that children's most likely decision related to disclosure of mental health concerns would differ significantly on a linear combination of two caregiver factors, parental care and overprotectiveness. This same procedure was used for the secondary hypothesis, replacing the parenting variables with beliefs and attitudes about mental illness and help-seeking in model 2. The third set of DFA focused on cultural predictors such as familism and acculturation/enculturation only with the families of the international subsample.

Results

Prior to conducting analyses to test our hypotheses, we carried out comparative tests between our groups. As shown in Table 2, pairwise comparisons indicated that domestic caregivers reported significantly ($t = -4.17$, $df = 38$, $p < .001$) lower levels of overprotectiveness on the PBI than did international caregivers. Additionally, domestic caregivers reported significantly more favorable views toward help-seeking ($t = 5.31$, $df = 38$, $p < .001$) and significantly less stigma ($t = -3.71$, $df = 38$, $p = .001$) compared to those from the international sample.

Hypothesis 1 – Caregiver Parenting Styles

The overall Chi-square test for parenting styles in the domestic sample in reference to the anxiety vignette was not significant (Wilks' $\lambda = .762$, Chi-square = 4.489, $df = 4$, Canonical correlation = .475, $p = .344$). In response to the depression vignette, the overall Chi-square for the domestic sample based on parenting styles was likewise non-significant (Wilks' $\lambda = .792$,

Chi-square = 3.851, *df* = 4, Canonical correlation = .454, *p* = .427). The results of the overall

Chi-square tests were similarly not significant among the international sample, both for the

anxiety vignette (Wilks' *λ* = .911, Chi-square = 1.538, *df* = 4, Canonical correlation = .298, *p* =

.820) and for the depression vignette (Wilks' *λ* = .892, Chi-square = 1.894, *df* = 4, Canonical

correlation = .327, *p* = .755). Table 4 presents the standardized discriminant function coefficients

for all analyses and Table 5 shows the functions at the group centroids. Reclassification of cases

based on new canonical variables was not successful with regard to parenting variables: less than

60% of cases were correctly classified into the original categories for all conditions.

Hypothesis 2 – Caregiver Attitudes toward Help-Seeking & Mental Illness

A second set of DFA was carried out to test the second hypothesis that children's most

likely decision related to disclosure of mental health concerns would differ significantly on a

linear combination of two factors related to parental mental health attitudes: attitudes toward

help-seeking and beliefs toward mental illness. In the domestic sample, again the overall Chi-

square tests were non-significant in reference to the anxiety vignette (Wilks' *λ* = .889, Chi-square

= 1.945, *df* = 4, Canonical correlation = .332, *p* = .746). The test for the domestic group

regarding the depression vignette approached significance, but was ultimately not significant

(Wilks' *λ* = .596, Chi-square = 8.529, *df* = 4, Canonical correlation = .566, *p* = .074). For the

international sample, the results were similar with respect to the anxiety vignette (Wilks' *λ* =

.596, Chi-square = 8.527, *df* = 4, Canonical correlation = .587, *p* = .074). The overall Chi-square

test for the international group's depression vignette, likewise, was not statistically significant

(Wilks' *λ* = .859, Chi-square = 2.516, *df* = 4, Canonical correlation = .349, *p* = .642).

Hypothesis 3 – Cultural Factors among International Families

For hypothesis 3, we conducted a final set of DFA to test whether the most likely decision related to disclosure of mental health concerns among children of international families would differ significantly on a linear combination of three factors associated with their caregivers' cultural background: ethnic society immersion (i.e., enculturation), dominant society immersion (i.e., acculturation), and familism. The overall Chi-square test for the anxiety vignette was significant (Wilks' λ = .386, Chi-square = 15.230, df = 6, Canonical correlation = .729, p = .019); the two functions extracted accounted for over 60% of the variance in international children's likely decision of whether to speak up about anxiety. Table 4 presents the standardized discriminant function coefficients, with DSI as the most heavily loaded factor in Function 1. Function 1 can be referred to as "acculturation." Reclassification of cases based on these canonical variables was highly accurate: when discriminant functions were used to predict children's decisions based on the cultural variables, 80% of the original grouped cases were correctly classified back into their original categories. Subsequent post-hoc pairwise analyses suggest that the group centroids (see Table 5) for disclosure and withholding did not differ from one another (Mean Diff. = 0.034, SE = .570, p = .953) but that masking differed significantly from disclosure (Mean Diff. = 2.073, SE = .518, p = .001) and withholding (Mean Diff. = 2.039, SE = .586, p = .003). However, the results did not hold up for the depression vignette, as the overall Chi-square test for which was not statistically significant (Wilks' λ = .780, Chi-square = 3.985, df = 6, Canonical correlation = .465, p = .679).

Discussion

The present study sought to expand on the existing literature for child help-seeking and disclosure of mental health concerns by incorporating various elements that have been previously implicated, and analyzing these constructs using a novel approach among a diverse sample. Our

results complement extant research by shedding new light on some of the caregiver factors that influence children's willingness to speak up about potential symptoms of mental illness related to anxiety and depression.

Despite a considerable body of research linking parenting and children's disclosure and/or secrecy (Almas, Grusec, & Tackett, 2011; Darling, Cumsille, Caldwell, & Dowdy, 2007), we did not find this to be the case in our sample. Our preliminary analyses comparing our two groups – international and domestic families – are consistent with literature suggesting parents of international or minority populations display greater overprotectiveness (Domenech-Rodriguez, Donovick, & Crowley, 2009). We found no evidence, however, to support parenting style as having a significant impact on children's propensity to disclose internalizing conditions (i.e., anxiety and depression) among domestic or international families. It is important to consider possible explanations for this finding, given prior research which has shown parenting factors to exert an effect (Soenens, Vansteenkiste, Luyckx, & Goossens, 2006; Vieno, Nation, Pastore, & Santinello, 2009).

Disclosure and secrecy are increasingly understood to represent related but separate constructs, particularly when addressing the influence of parenting. It is unclear whether our approach (i.e., an indirect vignette with open-ended prompts) tapped solely disclosure or inherently combined the two constructs. In other words, when given concrete action-oriented options (i.e., disclose, withhold, or mask) in response to an open-ended prompt (e.g., "[his/her] mother asks [him/her] how [he/she] is doing"), children's decisions could reflect either disclosure or secrecy; it is not readily apparent how a given child interpreted the prompt. If they interpreted the inquiry to be poignantly directed at existing mental health concerns (e.g., "is something bothering you?") from the vignette, masking or withholding would ostensibly

constitute secrecy. If, on the other hand, they interpreted this inquiry as a general opportunity to talk with parents (e.g., "tell me about your day"), their responses might capture the notion of disclosure versus nondisclosure.

Moreover, much of the past literature has relied on self-report indices of disclosure and secrecy, which ostensibly capture different facets of children's inclinations than would an interactive vignette. In fact, Almas et al. (2011) made note of this, calling for similar research questions to be addressed with a wider variety of methodologies. Ours represents one such contribution, but the implications that can be drawn remain limited. That is, we only included caregiver styles based on parental care and overprotectiveness. Other parental factors—including parenting practices (e.g., parental monitoring, positive praise, corporal punishment) which are separate from parenting styles—may influence dispositions toward help-seeking or disclosure in children in different ways. Of course, it is equally likely that our findings point to a weaker relationship between parenting and children's help-seeking than previously thought.

With respect to caregiver attitudes and beliefs toward mental health and children's likely decisions on disclosure, we found no statistically significant evidence to suggest an association. Still, based on descriptive analyses between our two samples, we found evidence in support of past research indicating that cultural minorities – including ethnic and racial minorities – tend to be less inclined toward seeking professional mental help and to hold more stigmatized views (Lindsey et al., 2013; McMiller & Weisz, 1996). Nevertheless, our findings indicate that children's preferred decision to speak up, withhold, or mask internalizing symptoms is not contingent on the attitudes held by their parents on such things as seeking professional help or their own beliefs toward mental illness. Given that this remains an understudied area of research, the lack of support found for the influence of parenting style on disclosure in this study is not

altogether surprising. Although there is literature examining parental influence on children's

acquisition of values (Grusec, Goodnow, & Kuczynski, 2000) and schemas (Dunsmore &

Halberstadt, 1997), relatively little is known about the transference of beliefs and attitudes from

caregivers to children, especially in reference to mental health. Within the framework of the

help-seeking model for children, then, it may be that views toward help-seeking or disclosure can

differ for children and caregivers. In other words, in a particular hypothetical family, a caregiver

might hold stigmatized views of mental illness or have reservations about seeking professional

help, but the child will not necessarily be unwilling to disclose their mental health concerns to

his or her parent. As such, in some instances, children may be willing to disclose their

internalizing difficulties to other advocates (e.g., teachers) who may hold more positive views

toward mental health and mental illness than caregivers. Future research is called on to explore

these different avenues for children struggling with concerns.

In view of the literature on the active role parents play in seeking formal services for

youth (Mayberry & Heflinger, 2013; Sayal, 2006), this means that other factors outside of

parental attitudes may better predict whether children will at least initiate the help-seeking

process. While the results fell just short of statistical significance, they may tentatively point to a

possible emerging relationship, qualified by small sample sizes, in two of these analyses. For

children of domestic families responding on depression—but not anxiety—it may be informative

to know caregivers' attitudes and beliefs when predicting children's likely response, although the

particular beliefs may need to be specified further (e.g., interpersonal openness, stigma,

confidence in mental health practitioner). This pattern of discrepancy in the findings related to

anxiety versus depression was apparent throughout; if a link can be more substantively

established by future studies or exploratory analyses, it might indicate that parental beliefs factor

into children's disclosure-related decisions differently, perhaps depending on symptomatology. However, in order to better examine the nature of parental beliefs and how these may shape child views, it will be distinctly important to include the degree to which children are aware of their parents' attitudes, which we did not address in the current study. We also approached significance on our analyses of international-born families responding on anxiety, but not depression. Together, these findings suggest that culture and parental factors might interact to confer certain dispositions in children's reporting for specific internalizing difficulties.

As for our third hypothesis, on whether decisions for disclosure made by children of international families differed based on a linear combination of cultural factors, we found evidence that this was the case when disclosing about anxiety, but not depression. Based on the standardized canonical discriminant function coefficients shown in Table 4, we see that Function 1 can be broadly defined as "acculturation" based on the high positive loading of dominant society immersion and the comparatively lower ethnic identity immersion and attitudinal familism. Our findings suggest that cultural factors can best differentiate between a child's choice to mask versus withhold or disclose. Again, these results highlight the contrast between disclosure and secrecy (Almas et al., 2011; Frijns et al., 2010). The decision to deliberately mask internalizing symptoms by presenting a positive front to caregivers most closely aligns with the construct of secrecy.

From our findings, children of international families were more likely to mask their concerns when caregivers demonstrated low levels of acculturation. This is consistent with prior research, which suggests that acculturation is typically associated with more favorable views toward help-seeking among adults (Han & Pong, 2015), although *how* acculturation in the family may impact children remains understudied. Ethnic society immersion was comparatively

unimportant, as were values associated with familism. However, to the degree that they factored into the model, contrary to what we anticipated, all three factors loaded positively. Previous studies found similar emerging evidence to support the notion that enculturation—that is, an adherence to one's traditional cultural values—may actually encourage help-seeking among Mexican Americans (Ramos-Sanchez & Atkinson, 2009). Another study by Keeler, Siegel, and Alvaro (2014) found that familism was positively associated with favorable perceptions of help-seeking, but only for informal sources such as family, not necessarily for professionals. Together, the results of our study and previous research suggest a more unidirectional role for cultural immersion than previously believed based on cultural barrier theory (Leong, Wagner, & Tata, 1995).

This study is not without limitations, several of which qualify the conclusions that can be drawn from these results. For one, to get at childhood help-seeking using a more interactive methodology than self-report, the study employed open-ended instructions and newly developed techniques that have not yet been substantiated or validated. This was intended to be an exploratory and innovative approach to capture facets of childhood disclosure that had been previously difficult to study. Even in terms of self-report measures, few instruments have been validated and established for children; most studies have relied on either coded qualitative descriptions or data on service utilization. The approach taken in this study to examine child disclosure was novel, and may serve as an informative supplement to these other, more widely used approaches. Nevertheless, there are obvious limitations associated with such methodology. For one, future multitrait-multimethod analyses that include child- and other-report measures, observational indices, and service use data are called for to elucidate how this form of assessment compares.

Moreover, our work focused on help-seeking targeted at a caregiver and brought on by external factors (e.g., anxiety about schooling, friends, etc.). In line with the aims of teasing apart various help-seeking components, future studies should compare how specific sources of internalizing concerns might also influence disclosure propensity. For example, it is possible that children with separation anxiety or anxiety centered on family may be more affected by parental or cultural factors than those who struggle with other forms or areas of worry (e.g., performance, panic attacks, depression). Similarly, the results may play out differently were paternal figures included. Additional research is needed with greater sample sizes and more varied caregiver-child dynamics to more definitively establish any observed findings. In fact, it will be important to extend this type of methodology and apply it to children struggling with clinical concerns, given that our sample drew from a community population without preexisting mental health concerns.

Also, due to demographic constraints within the geographic area, our comparisons between domestic-born and international families are somewhat confounded by the location at which the majority of the families in each group were recruited (i.e., domestic-born families in Virginia and international families in Florida). The examined parental or cultural factors may interact differently with the sociocultural climate of these different regions and skew the findings. Similarly, our international sample was not held to a specific ethnic identity or race (e.g., Hispanic, Asian, etc.); while this allowed us to analyze cross-cutting cultural themes and influences, it characterizes the current sample as inherently heterogeneous—although predominantly Hispanic—and thereby limits the interpretations we can make to some degree.

Despite these limitations, the present study provides early support for the environmental and familial influences on children's disclosure of internalizing disorders using a new approach.

Our findings can begin to inform outreach efforts for caregivers and children within a culturally sensitive framework. Including additional factors or fine-tuning the constructs in subsequent research based on our emerging results will provide a better understanding of how we can facilitate children's self-disclosure to promote recognition and service use, especially among ethnic diverse and under-served families (McMiller & Weisz, 1996).

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Tables

Table 1.
Demographic Variable Counts & Percentages

	N (%)		
	Domestic	International	Total
Child Gender			
Female	6 (30%)	10 (50%)	16 (40%)
Male	14 (70%)	10 (50%)	24 (60%)
Child Ethnicity			
Arabic / Middle Eastern	0 (0%)	1 (5%)	1 (2.5%)
Asian	0 (0%)	2 (10%)	2 (5%)
Black	3 (15%)	0 (0%)	3 (7.5%)
Hispanic	0 (0%)	16 (80%)	16 (40%)
White	17 (85%)	1 (5%)	18 (45%)
Child Treatment			
No	16 (80%)	20 (100%)	36 (90%)
Yes	4 (20%)	0 (0%)	4 (10%)
Caregiver			
Mother	19 (95%)	13 (65%)	32 (80%)
Grandmother	0 (0%)	5 (25%)	5 (12.5%)
Stepmother	1 (5%)	2 (10%)	3 (7.5%)
Caregiver Marital Status			
Married	18 (90%)	11 (55%)	29 (72.5%)
Divorced / Separated	1 (5%)	2 (10%)	3 (7.5%)
Single / Never Married	1 (5%)	3 (15%)	4 (10%)
Widowed	0 (0%)	4 (20%)	4 (10%)
Caregiver Education			
H.S. Diploma / GED	1 (5%)	5 (25%)	6 (15%)
Some College	1 (5%)	4 (40%)	5 (12.5%)
Community College	0 (0%)	2 (10%)	2 (5%)
Associate's	1 (5%)	2 (10%)	3 (7.5%)
Bachelor's	8 (40%)	3 (15%)	11 (27.5%)
Master's	8 (40%)	2 (10%)	10 (25%)
Doctorate	1 (5%)	2 (10%)	3 (7.5%)
Gross Annual Income			
$26k - $50k	2 (10.5%)	6 (30%)	7 (17.9%)
$51k - $75k	5 (26.3%)	8 (40%)	13 (33.3%)
$76k - $100k	4 (21.1%)	3 (15%)	7 (17.9%)
$101k - $200k	6 (31.6%)	2 (10%)	8 (20.5%)
More than $200k	2 (10.5%)	1 (5%)	3 (7.8%)

Table 2.
Continuous Variables Means and Standard Deviations

	M (SD)			Pairwise Comparisons	
	Domestic	International	Total	t (df)	p
AGE	10.30 (1.13)	10.50 (1.10)	10.40 (1.11)	-.57 (38)	.574
CBCL	48.30 (10.74)	53.65 (11.49)	50.98 (11.30)	-1.52 (38)	.136
CARE	33.30 (3.28)	31.25 (3.21)	32.28 (3.37)	2.00 (38)	.053
OP	10.60 (3.87)	16.45 (4.95)	13.53 (5.29)	-4.17 (38)	<.000**
ATSPPHS	64.50 (12.02)	42.75 (13.82)	53.63 (16.88)	5.31 (38)	<.000**
BMI	35.70 (17.74)	54.50 (14.16)	45.10 (18.48)	-3.71 (38)	.001**
AFS	5.93 (1.13)	6.41 (1.29)	6.17 (1.22)	-1.25 (38)	.219
DSI	-	38.20 (10.69)	-	-	-
ESI	-	58.25 (7.66)	-	-	-

Note. CBCL = Child Behavior Checklist Internalizing T-Score; CARE = Parental Bonding Instrument Care (PBI) subscale; OP = PBI Overprotectiveness subscale; ATSPPH = Attitudes Toward Seeking Professional Psychological Help Scale; BMI = Beliefs toward Mental Illness; INC = Household Gross Annual Income; ESI = SMAS Ethnic Society Immersion subscale; DSI = Stephenson Multigroup Acculturation Scale (SMAS) Dominant Society Immersion subscale; AFS = Attitudinal Familism Scale.
* $p < .050$, ** $p < .010$

Table 3.
Correlations among Study Variables Separated by Domestic and International Samples

	1	2	3	4	5	6	7	8	9	10	11	12	13
1. AGE	—	-.218	.096	-.248	.174	.246	-.109	.241	.462*	.282	-.316	-.037	-.005
2. GEN	-.187	—	.125	.174	-.246	.278	.335	-.447*	-.061	-.113	.329	.215	.132
3. CBCL	-.031	-.281	—	.286	-.173	-.041	.065	.169	.005	.268	.006	.013	-.326
4. INC	-.166	-.267	-.026	—	.122	.069	.427	-.473*	-.270	.293	.061	.051	-.286
5. CARE	-.306	-.016	.175	.142	—	.263	.027	.012	.513*	-.217	-.264	-.157	-.071
6. OP	.082	.031	-.086	.057	.387	—	.094	.084	.423	-.230	-.025	.086	.245
7. ATSPPHS	-.220	.071	.069	.304	.338	.018	—	-.503*	-.180	.486*	-.072	-.047	.110
8. BMI	.098	.123	.230	-.358	-.097	-.036	-.737**	—	.091	-.033	-.123	.032	.236
9. AFS	.085	.077	-.056	-.065	.243	.038	.022	.157	—	-.015	-.398	-.030	-.129
10. DSI	.089	-.038	.035	.471*	.296	.148	.720**	-.768**	-.022	—	.023	.221	.309
11. ESI	-.241	.181	-.295	-.394	-.255	-.067	-.485*	.545*	-.113	-.662**	—	.293	.205
12. ANX	-.189	.058	-.100	-.247	-.051	.161	-.490*	.572**	-.068	-.665**	.537*	—	.245
13. DEP	-.384	.165	-.310	-.069	.083	.300	.111	-.149	-.023	-.039	-.024	.372	—
DOM α	-	-	-	-	.806	.507	.895	.928	.882	.442	.924	-	-
INT α	-	-	-	-	.656	.784	.921	.880	.911	.911	.867	-	-

Note. Intercorrelations are presented above the diagonal for the domestic group and below the diagonal for the international group. GEN = Gender; CBCL = Child Behavior Checklist Internalizing T-Score; INC = Annual Income; CARE = Parental Bonding Instrument (PBI) Care; OP = PBI Overprotectiveness; ATSPPH = Attitudes Toward Seeking Professional Psychological Help Scale; BMI = Beliefs toward Mental Illness; AFS = Attitudinal Familism Scale; DSI = Stephenson Multigroup Acculturation Scale (SMAS) Dominant Society Immersion; ESI = SMAS Ethnic Society Immersion; ANX = Top Ranked Choice for Anxiety Vignette; DEP = Top Ranked Choice for Depression Vignette; DOM = Domestic Sample; INT = International Sample
* $p < .050$, ** $p < .010$

Table 4.
Standardized Canonical Discriminant Function Coefficients

	Domestic Families				International Families			
	Anxiety		Depression		Anxiety		Depression	
Variables	Function 1	Function 2	Function 1	Function 2	Function 1	Function 2	Function 1	Function 2
Hypothesis 1								
CARE	1.020	-.168	-.428	.962	-.663	.878	-.189	1.067
OP	-.095	1.029	1.048	.105	1.074	.237	1.057	-.235
Hypothesis 2								
ATSPPHS	-.076	1.135	.925	6.15	-.141	1.338	1.504	.181
BMI	.962	.608	-.150	1.101	.900	1.000	1.010	1.129
Hypothesis 3								
DSI	-	-	-	-	1.083*	.537	.769	.953
ESI	-	-	-	-	.144*	1.170	.107	1.291
AFS	-	-	-	-	.331*	.521	.830	-.019

Note. CARE = Parental Bonding Instrument Care (PBI) subscale; OP = PBI Overprotectiveness subscale; ATSPPH = Attitudes Toward Seeking Professional Psychological Help Scale; BMI = Beliefs toward Mental Illness; INC = Household Gross Annual Income; ESI = SMAS Ethnic Society Immersion subscale; DSI = Stephenson Multigroup Acculturation Scale (SMAS) Dominant Society Immersion subscale; AFS = Attitudinal Familism Scale.
* $p < .050$

Table 5.
Functions at Group Centroids

| | Domestic Families | | | | International Families | | | |
| | Anxiety | | Depression | | Anxiety | | Depression | |
Variables	Function 1	Function 2	Function 1	Function 2	Function 1	Function 2	Function 1	Function 2
Hypothesis 1								
Disclosure	.445	-.099	-.138	.044	-.329	.003	-.232	-.024
Withholding	-.816	-.066	-.833	-.074	.377	.008	-.243	.079
Masking	.075	.159	.554	-.032	.107	-.009	.435	.001
Hypothesis 2								
Disclosure	-.212	.032	.151	-.335	-.664	.207	-.141	.126
Withholding	.561	.004	-1.479	.157	-.155	-.497	.818	-.004
Masking	-.158	-.039	.418	.411	.870	.118	-.149	-.179
Hypothesis 3								
Disclosure	-	-	-	-	.734[A]	-.413[A]	-.125	.063
Withholding	-	-	-	-	.700[A]	.671[A]	1.137	-.027
Masking	-	-	-	-	-1.339[B]	-.008[A]	-.309	-.078

Note. For International Families responding in reference to Anxiety, means within each column (function) having the same letter in their superscripts are not significantly different from each other at the $p = .05$ level.

Appendix A

DISCLOSURE VIGNETTE ACTIVITY: INSTRUCTIONS

Scoring

Decisions	Rationale	
[F] *Full Disclosure*	[A] *Acceptance*	[B] *Burden*
[P] *Partial Disclosure*	[H] *Hopelessness*	[I] *Isolation*
[W] *Withholding / Nondisclosure*	[L] *Lack of Insight*	[S] *Stigma*
[M] *Masking*		

Session Preparation

1. Prior to participant arrival, fill out the Disclosure Vignette Activity (DVA) scripts with the child's gender (green pronouns), the child's age, the participating caregiver's relationship to the child (e.g., mom, aunt, grandma, etc.).

2. Make sure that you have all of the cue cards and the response sheet (use checklist to verify).
   - ❐ 4 *Anxiety Cue Cards*
   - ❐ 6 *Anxiety Thought Cards*
   - ❐ 4 *Depression Cue Cards*
   - ❐ 6 *Depression Thought Cards*
   - ❐ 1 Response Sheet

Administration Protocol

1. Once the child is in the room, ask if they need to use the restroom or if they would like a drink.

2. Spend the first couple of minutes building rapport by asking how their day is going, and if they did anything fun or have any fun plans.

3. Once the child seems comfortable and engaged, begin protocol:

First, we're going to go over a couple of short stories. I want you to listen carefully and think about what each (*boy / girl*) is going through. When I finish, we'll talk about some of (*his / her*) options together. There is no right or wrong answers; I'm just interested in knowing your own personal thoughts. Ready?

YES: **Okay, great, let's get started.**

NO: Answer questions and then check again before proceeding. **Okay, so are you ready to begin?**

VIGNETTE 1: ANXIETY

The first story is about Jaime, a(n) (___*age*___)-year-old (*boy / girl*) who is *always* worrying about all kinds of things! For example, (*he / she*) constantly worries about schoolwork and has to redo it several times because (*he / she*) thinks (*he / she*)'s going to get a bad grade or that (*his / her*) friends will think (*he / she*)'s dumb if (*he / she*) doesn't get it perfect. Jaime also worries about the future a whole lot, like about bad things that might happen tomorrow, whether (*he / she*)'ll be successful and happy or end up all alone. Not only does Jaime worry about what's going to happen or what *might* happen, (*he / she*) also worries about the past. (*He / She*) always thinks something (*he / she*) said or did was bad or that other people might have thought badly of (*him / her*) for no particular reason, and won't like (*him / her*) anymore. On top of that, Jaime spends a lot of time worrying about (*his / her*) family and friends: (*he / she*)'s always scared that (*his / her*) (___*caregiver*___) will get sick or that something bad might happen to her.

Whenever Jaime worries—which is most of the day, and almost every single day—(*his / her*) heart starts to speed up, (*he / she*) can't concentrate on any activities or tasks, and (*he / she*) gets so overwhelmed that (*he / she*) can't even sleep at night! However, although this has been going on for as long as Jaime can remember, (*he / she*) hasn't ever really talked to anyone about these worries.

(*Caregiver Prompt*): **One day, Jaime is in the car with (*his / her*) (___*caregiver*___) after being picked up from school and is feeling very anxious. Then, as usual, (*his / her*) (___*caregiver*___) asks (*him / her*) how (*his / her*) day went and how (*he / she*) is doing.**

Before we look at some of (*his / her*) options more specifically, how do you think Jamie will most likely respond? _____

_____

Okay, so Jaime could:

Present each of the Anxiety Cue Cards *to the child at random and read them aloud.*

Now, I want you to think about these four options and rank them in order of *most likely* to *least likely* on this chart. Fill in the code for each ranking:

_____ Most Likely (1)

_____ Likely (2)

_____ Not Likely (3)

_____ Least Likely (4)

** Note: Remove cards from response sheet and shuffle them before continuing with the other target source **

(*Teacher Prompt*): **In another instance, Jaime is at school, fidgeting nervously because of all these worries. Jaime has always gotten along really well with (*his / her*) teacher, Ms. G. Today, she comes up to (*him / her*) and asks how things are going.**

Again, before we look at some of Jaime's options, how do you think (*he / she*) will likely respond to (*his / her*) teacher, Ms. G.? _____

_____

Okay, so again Jaime could:

Present each of the Anxiety Cue Cards to the child at random and read them out loud.

Again, I want you to think about these four options and rank them in order of *most likely* to *least likely* on the chart. Think about how Jaime will most likely act with a teacher. Fill in the code for each ranking:

_____ Most Likely (1)

_____ Likely (2)

_____ Not Likely (3)

_____ Least Likely (4)

Great! Now I want you to use this other board and these cards, *show the child the Anxiety Thought Cards,* **to fill in why Jaime might make each decision. In other words, what do you think is most likely going through (*his / her*) head that would lead (*him / her*) to make each choice? We'll go through each option together. You can pick up to four thoughts that you think apply, but it is okay to pick only one, two, or three.** *Start with any option at random, and place it on the 'Option' space in the Response Sheet.* Record the code on the protocol. *Then, read each of the thought cards to the child. Provide clarification as needed.* Fill in the code for the rationale for each decision based on the child's responses:

[_____]	[_____]	[_____]	[_____]
1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____
3. _____	3. _____	3. _____	3. _____
4. _____	4. _____	4. _____	4. _____

Okay, now I want to ask you just a couple of questions about the story we talked about. Is that okay?
Administer STORY 1 QUIZ. *Help child with reading or explanations as needed.*

VIGNETTE 2: DEPRESSION

This second story is about another (___*age*___)-year-old (*boy / girl*) named Alex. Growing up, Alex was a shy but likeable child and a gifted little artist! However, for the past couple weeks Alex has been feeling really sad almost all the time. Even when (*he / she*)'s not feeling down, (*he / she*) just gets frustrated or grouchy for no apparent reason. (*He / She*) doesn't really know when these feelings first started, but lately Alex just wants to stay in (*his / her*) room after school instead of spending time with friends or doing anything fun or productive. In fact, (*he / she*) has lost all interest in drawing or making crafts, which (*he / she*) used to love. Alex always feels tired even though most of (*his / her*) time is spent sleeping or lounging at home. (*He / She*) has also stopped eating regularly because it almost seems like food has no taste anymore.

Some days are even worse! Sometimes, Alex will lock (*himself / herself*) in (*his / her*) room and quietly cry for hours. For a while now, Alex has felt like nobody cares about (*him / her*) and like nothing will ever work out. In fact, recently (*he / she*)'s started to think that nobody would even miss (*him / her*) if (*he / she*) disappeared. Even though Alex is so sad all the time, (*he / she*) has never said anything to anyone about all this.

(*Caregiver Prompt*): **One morning, Alex wakes up feeling really sad and tired as usual. (*He / She*) doesn't even feel like getting out of bed because life seems pointless. Alex's (___*caregiver*___) comes in to get (*him / her*) ready for school, and asks how (*he / she*) is feeling.**

Before we look at some of Alex's options more closely, how do you think (*he / she*) will respond with (*his / her*) (___*caregiver*___)? _____

_____

Okay, so Alex could:

Present each of the Depression Cue Cards *to the child at random and read them aloud.*

Now, I want you to think about these four options and rank them in order of *most likely* to *least likely* on the chart. Fill in the code for each ranking:

_____ Most Likely (1)

_____ Likely (2)

_____ Not Likely (3)

_____ Least Likely (4)

** Note: Remove cards from response sheet and shuffle them before continuing with the other target source **

(*Teacher Prompt*): **In another instance, Alex is at school, trying not to cry during recess. Alex has always gotten along well with (*his / her*) teacher, Ms. B., and she sees (*him / her*) crying all alone, so she asks what's the matter.**

Again, before we look at some of Alex's options more closely, how do you think (*he / she*) will respond with (*his / her*) teacher, Ms. B.? _____

_____

Okay, so again, Alex could:

Present each of the Depression Cue Cards to the child at random and read them out loud.

Again, thinking about Ms. B., I want you to consider these four options and rank them in order of *most likely* to *least likely*. Fill in the code for each ranking:

_____ Most Likely (1)

_____ Likely (2)

_____ Not Likely (3)

_____ Least Likely (4)

Great! Now, like before, I want you to use the cards, *show the child the Depression Thought Cards,* **to fill in why Alex might choose each of those options. So, again, what do you think is most likely going through (*his / her*) head that would lead to that choice? Just like last time, we'll go through each option together. Remember, you can pick up to four thoughts that you think apply, but it is okay to pick only one, two, or three.** *Start with any option at random, and place it on the designated space in the Response Sheet.* Record the code on the protocol. *Then, read each of the thought cards to the child. Provide clarification as needed.* Fill in the code for the rationale for each decision based on the child's responses:

[_____]   [_____]   [_____]   [_____]

1. _____   1. _____   1. _____   1. _____

2. _____   2. _____   2. _____   2. _____

3. _____   3. _____   3. _____   3. _____

4. _____   4. _____   4. _____   4. _____

Just like last time, now I want to ask you a couple of questions about the story we talked about.
Administer STORY 2 QUIZ. *Help child with reading or explanations as needed.*

Disclosure Vignette Activity Cue Cards

	Partial Disclosure	Full Disclosure	Withholding	Masking
Anxiety	Speak up about all the constant worrying in detail, like how serious it is	Say something is wrong, but still be a little unclear about it	Just say that it's nothing and change the conversation	Act like everything is great and like there's nothing to worry about
Depression	Go into detail about the bad emotions, like just how hard it has been to deal with this	Just say it's a bad mood, but nothing too specific	Simply say it isn't a big deal and try to talk about something else	Pretend to be happy and say that things are perfectly fine

Disclosure Vignette Activity Thought Cards

	Acceptance	Burden	Hopelessness	Isolation	Lack of Insight	Stigma
Anxiety	"I really can't deal with this by myself"	"Other people shouldn't have to deal with my problems"	"There's nothing anyone can do to make me worry less"	"No one actually cares about my personal worries"	"All kids worry just as much about these things so it's normal"	"Kids who complain about their worries are just being dramatic"
Depression	"Someone else might know how to help me feel better"	"I shouldn't ruin everyone else's mood with my problems"	"No one can make help make these sad feelings go away"	"Nobody is interested in my emotional problems"	"Everyone goes through periods when they feel really sad for no reason"	"Only weak kids talk about feeling so sad"

Appendix B

Demographics Form

Personal History

1. Your child's name: _____

1. Your relationship to the child: _____

2. Today's date: ____ / ____ / ____

3. Child's age: _____ years _____ months

4. Child's gender: ☐ Male ☐ Female ☐ Other (e.g., transgender)

5. Child's current grade level (summer: rising grade): _____

6. Your phone number: (_____) _____-_____

7. Your email address: _____

8. Your marital status:
   - ☐ Married
   - ☐ Long-term relationship or engaged
   - ☐ Divorced or separated
   - ☐ Single or never married
   - ☐ Widowed

9. Your highest level of education completed:
   - ☐ Less than high school
   - ☐ High school diploma or GED
   - ☐ Some college
   - ☐ Community college
   - ☐ Associate's
   - ☐ Bachelor's
   - ☐ Master's
   - ☐ Doctorate

10. Household annual gross income (estimated):
   - ☐ Less than $10,000
   - ☐ $10,000 - $25,000
   - ☐ $25,000 - $50,000
   - ☐ $50,000 - $75,000
   - ☐ $75,000 - $100,000
   - ☐ $100,000 - $200,000
   - ☐ $200,000 or more

11. Number of family members in your household: _____

12. Number of siblings your child has: _____

Ethnic and Cultural Background

13. Your race / ethnicity:
- ☐ White / Caucasian (non-Hispanic; non-Arabic)
- ☐ Black / African American, African (non-Hispanic)
- ☐ Hispanic, Latino(a)
- ☐ American Indian / Alaskan Native

- ☐ Arab / Middle Eastern, Arab-American
- ☐ Asian, Asian-American
- ☐ Pacific Islander
- ☐ Other: (Please specify)

_____

14. Your child's race / ethnicity:
- ☐ White / Caucasian (non-Hispanic; non-Arabic)
- ☐ Black / African American, African (non-Hispanic)
- ☐ Hispanic, Latino(a)
- ☐ American Indian / Alaskan Native

- ☐ Arab / Middle Eastern, Arab-American
- ☐ Asian, Asian-American
- ☐ Pacific Islander
- ☐ Other: (Please specify)

_____

Please fill out the chart below regarding your child's family background to the best of your knowledge:

Please check the box below that applies to you.	Born in the U.S.	Born in another country, but immigrated to the U.S.	Born in another country, and still reside outside of U.S.	Not sure or I prefer not to answer.
Your Child	☐	☐	☐	☐
☐ Child's Mother	☐	☐	☐	☐
☐ Maternal Grandmother	☐	☐	☐	☐
☐ Maternal Grandfather	☐	☐	☐	☐
☐ Child's Father	☐	☐	☐	☐
☐ Paternal Grandmother	☐	☐	☐	☐
☐ Paternal Grandfather	☐	☐	☐	☐
☐ Other: (Please specify) _____	☐	☐	☐	☐

15. Which country do you consider your nation of origin or native country?

Note: This does **not** necessarily mean you had to have been born there; only that you currently have significant cultural or ancestral ties to, or largely identify with that nation.

_____   Native Language: _____

Appendix C

Attitudes toward Seeking Professional Psychological Help Scale

Fischer, E. H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form

and considerations for research. Journal of College Student Development.

Appendix D

Attitudinal Familism Scale

Steidel, A. G. L., & Contreras, J. M. (2003). A new familism scale for use with Latino populations. Hispanic

Journal of Behavioral Sciences, 25(3), 312-330.

Appendix E

Beliefs toward Mental Illness Scale

Hirai, M., & Clum, G. A. (2000). Development, reliability, and validity of the beliefs toward Mental Illness

Scale. Journal of Psychopathology and Behavioral Assessment, 22(3), 221-236.

Appendix F

Parenting Bonding Instrument

Parker, G., Tupling, H., & Brown, L. (1979). A parental bonding instrument. British journal of medical

psychology, 52(1), 1-10.

Appendix G

Child Behavior Checklist

Achenbach, T. M. (1991). *Manual for the Child Behavior Checklist/4-18 and 1991 profile* (p. 288).

    Burlington,VT: Department of Psychiatry, University of Vermont.

Available for purchase at:

http://store.aseba.org/

Appendix H

Stephenson Multigroup Acculturation Scale

Stephenson, M. (2000). Development and validation of the Stephenson Multigroup Acculturation Scale

(SMAS). Psychological Assessment, 12(1), 77.